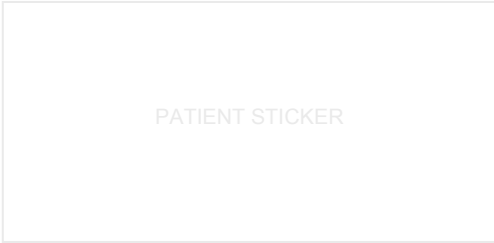


## SHOULDER EVALUATION

UCLA Sports Medicine

David R. McAllister, M.D.  
UCLA Medical Center  
Dept of Orthopaedic Surgery



### Chief Complaint:

### History of Present Illness:

Sports/level:  none  recreational  collegiate  competitive  semi-professional  professional

Date of injury: \_\_\_\_\_

No specific injury

**Handedness:**    **R**            **L**

Trauma             Yes     No

Dislocation       Yes     No

▪ Reduced         Self  
                       Emergency room

▪ How Many?    \_\_\_\_\_  
                       Anterior  
                       Posterior

Prior Injury       Yes     No

Clicking           Yes     No

Instability         Yes     No

Neck Injury        Yes     No

### Pain:

Location:     Anterior     Posterior     Lateral     Neck/Trapezius     Arm

Daytime Pain at Rest     Yes     No

Night pain                 Yes     No

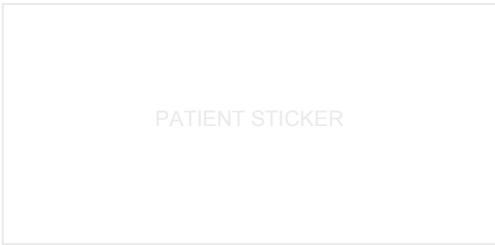
Activity Related Pain     Yes     No

Pain with Sports          Yes     No

Radiating Pain           Yes     No

Pain with overhead

Activity                     Yes     No



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**Prior Treatment:**

NSAID                     Improved     No Benefit     Did Not Try  
 Physical Therapy     Improved     No Benefit     Did Not Try  
 Injection               Improved     No Benefit     Did Not Try

▪ How Long? \_\_\_\_\_

Previous Surgery?     Yes     No

If yes, specify: \_\_\_\_\_

**Physical Examination:**

NECK:                  TENDERNESS:                  ROM:  
  
 SHOULDER:                  AFFECTED SIDE:                  R    L  
                                         Passive                          Active  
 ROM:                          R    L                          R    L

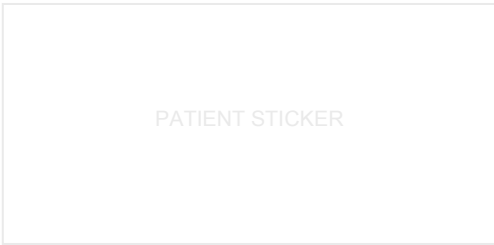
**Forward elevation:**

ER at side  
  
 ER at 90°  
  
 IR spine level

	R			L		
Neer's:	+	-	-	+	-	-
Hawkin's:	+	-	-	+	-	-
O'Brien's:						
▪ Palm up	+	-	-	+	-	-
▪ Palm down	+	-	-	+	-	-
X-body adduction:	+	-	-	+	-	-

**Strength:**

Abduction	0	1	2	3	4	5	0	1	2	3	4	5
ER	0	1	2	3	4	5	0	1	2	3	4	5



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<b>Instability:</b>	<b>R</b>			<b>L</b>		
Sulcus	1+	2+	3+	1+	2+	3+
Inferior	1+	2+	3+	1+	2+	3+
Anterior	1+	2+	3+	1+	2+	3+
Posterior	1+	2+	3+	1+	2+	3+
Apprehension Test:	+		-	+		-
Relocation Test:	+		-	+		-

DEFORMITY       AC Joint     SC Joint     Biceps

ATROPHY:

SCAPULAR WINGING:  Yes     No

TENDERNESS:       AC Joint     SC Joint       Biceps Tendon  
                           Deltoid       Post. Capsule     Trapezius  
                           SC Joint      Other: \_\_\_\_\_

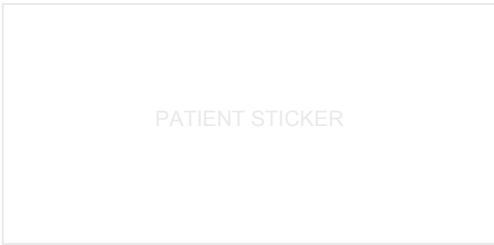
CREPITUS:             GH             AC             SC

Scapulothoracic Dyskinesia     Yes     No

Gait:     Normal  
            Antalgic  
            Thrust

Pulses:      **R**      **L**  
 Radial                  
 Brachial             

Sensation:    **R**      **L**  
 Radial nv.              
 Ulnar nv.                
 Median nv.              
 Axillary nv.



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<b>Radiographs:</b>	<b>R</b>				<b>L</b>			
AC JOINT:								
SC JOINT:								
TYPE OF ACROMIUM:	1	2	3		1	2	3	
GH JOINT:								
RTC ARTHROPATHY:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
MRI:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			ARTHROGRAM:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

	<b>R</b>	<b>L</b>
Rotator cuff tear	<input type="checkbox"/>	<input type="checkbox"/>
Partial rotator cuff tear	<input type="checkbox"/>	<input type="checkbox"/>
Rotator cuff tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
AC joint arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Impingement	<input type="checkbox"/>	<input type="checkbox"/>
Type _____ SLAP	<input type="checkbox"/>	<input type="checkbox"/>
Labral tear (Bankhart)	<input type="checkbox"/>	<input type="checkbox"/>
GH arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Other tests: \_\_\_\_\_

**Assessment:** \_\_\_\_\_  
 \_\_\_\_\_

**Plan:** \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 David R. McAllister, MD

\_\_\_\_\_  
 Date